



TITLE: Documentation Requirements for the Medical Record			
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Facility: Banner Churchill Community Hospital			
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Replaces:			
Approved by: Medical Executive Committee, Medical Staff, and Banner Board			

TITLE: *Documentation Requirements for the Medical Record*

I. Purpose/Expected Outcome:

- A. To ensure the documentation in the medical record meets generally accepted professional standards of documentation, specifically mandated regulatory, legal and/or accrediting standards and supports the documentation guidelines identified in the Medical Staff Rules and Regulations.
- B. The purposes of the Medical Record are:
 - 1. To serve as a detailed data base for planning patient care by all involved practitioners, nurses and ancillary personnel.
 - 2. To document the patient’s medical evaluation, treatment and change in condition during the hospital stay or during an ambulatory care or emergency visit,
 - 3. To allow a determination as to what the patient’s condition was at a specific time,
 - 4. To permit review of the diagnostic and therapeutic procedures performed and the patient’s response to treatment,
 - 5. To assist in protecting the legal interest of the patient, hospital and practitioner responsible for the patient and to provide data for use in the areas of quality and resource management, billing, education, and research.
- C. Charts will be completed according to Medical Staff Bylaws, Rules and Regulations. Records will be classified as delinquent if not completed in their entirety within seven (7) days after the patient’s discharge. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient.

II. Definitions:

- A. Authentication: The term “Authentication” means to establish authorship by written or electronic signature and shall consist of the practitioner’s name and professional title indicating the professional credential.
- B. HIMS – Health Information Management Services
- C. EMR – Electronic Medical Record
- D. Physician/Practitioner: For the purposes of this policy, physician/practitioner includes physicians dentists, podiatrists, advanced practice nurses, physician assistants, and other credentialed practitioners to give orders, provide consultations and/or perform surgical procedures.
- E. Supervisory Practitioner – The supervisory practitioner is defined as a staff physician at Banner Churchill Community Hospital, as appropriate, who has oversight responsibility for all aspects of patient care rendered by students and residents.



III. Policy:

- A. It is the policy of Banner Churchill Community Hospital to provide a medical record of the patient that is a timely, meaningful, authentic and legible description of the patient's clinical condition and hospital course. The following documentation requirements have been developed for this purpose.
- B. A Medical Record is established and maintained for each patient who has been treated or evaluated at Banner Churchill Community Hospital (BCCH). The Medical Record, including electronic data, medical imaging, pathological specimens and slides, are the property of BCCH.

IV. Procedure/Interventions:

A. General Requirements:

1. **Responsibility:** The attending physician is responsible for each patient's medical record. The medical record must identify who has primary responsibility for the care of the patient. Transfers of primary responsibility of the patient are not effective until documented in the clinical information system by the transferring physician and accepted on the clinical information system by the accepting physician. All clinical entries in the patient's record must be accurately dated, timed and individually authenticated by the responsible physician; group signing of documentation is not permissible. Authentication means to establish authorship by written or electronic signature and shall consist of the practitioner's name and professional title indicating the professional credential. Electronic signature authentication of medical records is the standard practice.
2. **Electronic Medical Record (EMR):** Banner Health is a "paper light" organization. As such, physicians need to adhere to record keeping practices that support the electronic environment. As much data as possible will be created electronically and paper-based documentation will be scanned. Records will be accessed by physicians and other users online and the records will not be printed for internal use. Selectively referred to herein as EMR.
3. **Use of EMR:** All medical record documents created after the patient is admitted will be created utilizing BH approved forms or BH electronic systems to allow for patient information to be exchanged and shared electronically among healthcare providers. This includes Operative Reports, Consultations, Discharge Summaries, and Progress Notes. The following documents are exceptions:
 - a. Documents from contracted/credentialed external sources that pertain to the delivery of patient care, such as radiology and telemedicine reports and select physician orders, with approval by the BH System Forms Committee. These reports must meet the time requirements and contain the data elements specified in the Medical Staff Rules and Regulations.
 - b. Banner Health approved forms and templates that are pre-populated and maintained by the provider with physician specific information such as consents and discharge instructions. These forms will be required to meet Banner Health forms template guidelines for bar-coding/scanning purposes and should not be photocopied by the provider. This exception does not apply to pre-populated forms maintained by Standard Register.
 - c. Other documents that are created utilizing BH unapproved forms or non-BH electronic systems after the patient is admitted may be accepted only through approval of the BH System Forms Committee.
4. **Access to the EMR:** Access to patient information on the EMR will be made available to Medical Staff and Allied Staff members and their staff through Clinical Connectivity. All access to electronic records is tracked and unauthorized access to a patient's record is not tolerated.
5. **EMR Training:** All Medical Staff, Allied Health Staff and Practitioners who are appointed to the Medical Staff or Allied Health Staff after August 9, 2011 pending electronic medical record training (EMR) and who have not completed this training within six (6) months of appointment



- may be considered to have voluntarily resigned from the staff. Practitioners will be advised of the training requirement at or prior to appointment and reminded of the requirement five (5) months from the date of appointment. Exceptions will be made on a case by case basis to be determined by the Medical Executive Committee and/or Hospital CEO.
6. **Release of Patient Information:** Banner Health releases patient information only on proper written authorization of the patient or as otherwise authorized by law and Banner policies. Medical Records may be removed from the Medical Center only in accordance with state and federal law, a court order, or subpoena, the permission of the Medical Center's Chief Executive Officer, or in accordance with Banner Health's policies. Unauthorized removal of an original medical record or any portion thereof from the Medical Center or disclosure of Patient Information constitutes grounds for disciplinary action.
 7. **Passwords:** All practitioners must maintain the confidentiality of passwords and may not disclose such passwords to anyone.
 8. **Legibility:** All practitioner entries in the record must be legible, pertinent, complete and current.
 9. **Copying and Pasting:** Physicians/Practitioners may not indiscriminately copy and paste documentation from other parts of the applicable patient's records. If copying a template, the Physician/Practitioner shall make modifications appropriate for the patient. If copying a prior entry, the Physician/Practitioner shall make appropriate modifications based upon the patient's current status and condition. The Physician/Practitioner must reference the date of a prior note as appropriate. When copying patient data into the medical record from another provider, the Physician/Practitioner must attribute the information to the person who performed the task unless it is readily apparent, based upon the nature of the information copied, that the data was entered by another provider. If referencing a form within the record, the form must be referenced with sufficient detail to identify the source. Example: "for review of systems, see form dated 6/1/10."
 10. **Information from Outside Sources:** Health record information obtained on request from an outside source is placed in the medical record and is available to the professional staff treating the patient. This information will contain the source facility name/address. Results of examination (Laboratory and X-Ray) performed prior to admission of the patient to BCCH and that are required for or directly related to the admission are made a part of the patient's hospital record.
 11. **Abbreviations:** Practitioners shall be responsible to use only approved symbols or abbreviations in the medical record. See Banner Health's policy "Medical Record Abbreviations and Symbols" List.
 12. **Counter-authentication (Endorsement):**
 - a. **Physician Assistants / Nurse Practitioners:** History and Physical Examinations and Discharge Summaries by the Physician Assistant and Nurse Practitioner will be counter authenticated timely by the applicable supervising physician as required the Allied Health Professionals Policy.
 - b. **Medical Students, Physician Assistant Students & Residents:**
 - i. **Medical Students:** A counter authentication from the supervisory practitioner is required timely on all orders prior.
 - ii. **Physician Assistant Students:** A counter authentication from the supervisory practitioner is required timely on all orders prior.
 - iii. **Residents:** Counter authentication from the attending supervisory practitioner will be required timely as follows per the Medical Student, Resident, Physician Assistant Privileges policy:
 - (i) **Admission History and Physicals**
 - (ii) **Orders:** A counter authentication from a supervisory practitioner is required timely for specific types of orders as follows:
 - (a) Chemotherapy orders



(b) Restraint Orders - The supervisory practitioner will counter authenticate the documented verbal order.

(c) Code Status order sheet

B. Medical Record Content

1. **Medical Record Documentation and Content:** The medical record must identify the patient, support the diagnosis, justify the treatment, and document the course and results of treatment and facilitate continuity of care. The medical record is sufficiently detailed and organized to enable:
 - a. The responsible practitioner to provide continuing care, determine later what the patient's condition was at a specified time, and review diagnostic/therapeutic procedures performed and the patient's response to treatment.
 - b. A consultant to render an opinion after an examination of the patient and review of the health record.
 - c. Another practitioner to assume care of the patient at any time.
 - d. Retrieval of pertinent information required for utilization review and/or quality assurance activities.

C. History and Physical Examinations ("H&P"):

A history and physical examination in all cases shall be completed by a physician, or Allied Health Professional who is approved by the medical staff to perform admission history and physical examinations, and placed in the patient's medical record within 24 hours after admission or registration for all inpatients and observation patients. The completed H&P must be on the medical record prior to surgery or invasive procedures, or any procedure in which anesthesia or procedural/moderate sedation will be administered or the case will be cancelled unless the responsible physician documents in writing that such delay would constitute a hazard to the patient. Guidelines for the H&P are as follows:

1. A legible office history and physical performed within 7 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. The updated examination must be completed and documented in the patient's medical record within 24 hours after registration or admission but prior to surgery or a procedure requiring anesthesia services.
2. The Obstetrical H&P will consist of the prenatal record, where applicable, updated in the EMR by the responsible physician or Allied Health professional.
3. The Emergency Department documentation form may not be used as a History and Physical.
4. If the complete history and physical was dictated shortly before the operation, but not yet transcribed, the surgeon/physician will document that the history and physical has been dictated.
5. A short H&P can be used for procedures using procedural/moderate sedation.
6. **Invasive Procedures:** The following procedures are considered invasive and must have an H&P:
 - a. Main OR procedures
 - b. Ambulatory Surgeries
 - c. C-section deliveries/tubal ligations
 - d. Endoscopies
 - e. Cardioversions
 - f. Lumbar Puncture
7. The prenatal record may be substituted for a history and physical but an interval admission note must be documented that includes pertinent additions to the history and subsequent changes in the physical findings. In the event a prenatal record is not present, a complete history and physical must be provided.
8. **Responsibility of the H&P:** The attending medical staff member is responsible for the H&P, unless it was already performed by the admitting medical staff member. H&Ps performed prior to admission by a practitioner not on the medical staff are acceptable provided that they are



- updated timely by the responsible physician. An oral surgeon with appropriate privileges who admits a patient without medical conditions may perform the H&P, and assess the medical risks of the procedure to the patient. Dentists and podiatrists are responsible for the part of their patients' H&P that relates to dentistry or podiatry, in addition to the medical history & physical.
9. Contents of the History and Physical Examination: Guidelines for the contents of the H&P include the following:
- a. Chief Complaint
 - b. Details of the present illness, including, when appropriate, assessment of emotional, behavioral and social status
 - c. Relevant past medical history, social and family history (as appropriate to the patient's age)
 - d. Any known allergies including past medication reactions and biological allergies
 - e. A list of current medications
 - f. System review including a minimum review of the cardiovascular, respiratory, genitourinary, and gastrointestinal systems.
 - g. Existing co-morbid conditions
 - h. Physical examination, current physical assessment to include all body systems, pelvic, rectal, breast exams, when applicable, and vital signs. If these are deferred, there must be a statement by the physician as to the reason for deferral, or results of recent exam.
 - i. Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination
 - j. Initial plan of action: Statement of the course of action planned for the patient while in the hospital.
 - k. For other outpatient (ambulatory) surgical patients, as necessary for treatment
 - i. Indications/symptoms for the procedure
 - ii. A list of current medications
 - iii. Any known allergies including past medication reactions
 - iv. Existing co-morbid conditions
 - v. Assessment of mental status
 - vi. Exam specific to the procedure performed.
 - l. IV Moderate Sedation: For patients receiving IV moderate sedation, a short H&P may be used plus the following:
 - i. Examination of the heart and lungs by auscultation
 - ii. American Society of Anesthesia (ASA) status
 - iii. Documentation that patient is appropriate candidate for IV moderate sedation.
- D. Emergency Department Reports:
A report is required for all Emergency Department visits and is expected to be completed within 24 hours of discharge/disposition from the Emergency Department. Guidelines for Emergency Department Reports:
1. Time and means of arrival
 2. Pertinent history of the illness or injury, including place of occurrence and physical findings including the patient's vital signs and emergency care given to the patient prior to arrival, and those conditions present on admission.
 3. Clinical observations, including results of treatment
 4. Diagnostic impressions
 5. Condition of the patient on discharge or transfer
 6. Whether the patient left against medical advice
 7. The conclusions at the termination of treatment, including final disposition, condition, and instructions for follow-up care, treatment and services.



E. Progress Notes

1. Must be documented/dictated on a daily basis, (patient must be seen by the physician at least once every 24 hours and recorded in form of the progress note).
2. Handwritten notes must be legible
3. Give a pertinent chronological report of patient's course
4. Reflect any change in condition
5. Reflect the results of treatment / response to therapy
6. Exceptions may be given to an obstetrical patient that has a discharge order entered for the day before.

F. Admitting Note:

The responsible provider must see the patient and document an admitting note (that justifies admission and determines the plan of treatment) within 24 hours of admission.

G. Consultation

If a consultation was requested by the physician, a satisfactory consultation includes examination of the patient and must be documented/ within 24 hours. When operative procedures are involved, the consultation shall be recorded prior to the operation (except in an emergency).

H. Operative and Procedure Reports

1. An operative report or other high-risk procedure report must be dictated or documented upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care.
2. The exception to this requirement occurs when an operative or other high-risk procedure progress note is documented immediately after the procedure, in which case the full report can be documented within 24 hours of the procedure.
3. If the practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be documented in the new unit or area of care.
4. Procedures requiring documented operative reports are identified under Invasive Procedures within this policy. Guidelines for the operative report:
 - a. Name of the procedure/operation
 - b. Preoperative diagnosis
 - c. Postoperative diagnosis
 - d. Name of primary surgeon and any assistants
 - e. Detailed account of the findings
 - f. Complications (if applicable)
 - g. Description of procedure(s) – technical procedures used
 - h. Specimens removed (if applicable)
 - i. Estimated blood loss
 - j. Condition after surgery
5. When a full operative or other high-risk procedure report cannot be documented immediately into the patient's medical record after the operation or procedure, a progress note is documented in the medical record before the patient is transferred to the next level of care. A post operative progress note must be documented immediately after the procedure providing sufficient and pertinent information for use by any practitioner who is required to attend the patient. Guidelines for the post operative note:
 - a. Postoperative diagnosis
 - b. Name(s) of the primary surgeon(s)



- c. Name(s) of the assistant(s),
 - d. Estimated blood loss
 - e. Specimen(s)
 - f. Procedures performed
 - g. Description of procedure finding
- I. **Informed Consent:** Prior to any operative procedures, the medical record must contain an informed consent. The practitioner doing such procedure(s) shall document in the medical record prior to the initiation of said procedure that informed consent was obtained from the patient or his/her legally constituted representative. Such documentation of informed consent shall include an indication that the patient or his/her legally constituted representative has been informed of the potential risks and benefits, potential problems related to recuperation, the likelihood of success, the possible results of non-treatment, and alternative courses of treatment.
- J. **Discharge Summary:**
1. A discharge summary must be documented at the time of discharge but no later than 24 hours after, by the responsible practitioner on all Inpatient and Observation hospitalizations 48 hours or greater in length. Normal newborns and normal vaginal deliveries do not require a discharge summary regardless of the length of stay. Guidelines for the-Discharge Summary:
 - a. Admitting diagnosis/reason for admission (recorded without abbreviations)
 - b. Concise final summary of diagnosis including any complications or co-morbidity factors (recorded without abbreviations)
 - c. Hospital course, including significant findings
 - d. Significant lab, x-rays, and physical findings
 - e. Procedures performed and treatment rendered.
 - f. Condition of the patient at discharge (describing limitations)
 - g. Instructions to the patient and family (to include activity, diet, medications, and follow-up appointments)
 2. Discharge Progress note may be substituted for a discharge summary and should be documented immediately upon discharge but no later than 24 hours post discharge, for inpatient stays less than 48 hours, observations, normal newborn and normal vaginal delivery cases. The note shall include:
 - a. Final diagnosis(es)
 - b. Patient's condition at discharge
 - c. Discharge instructions to patient and/or family
 - d. Follow-up care
- K. **Documentation of Death:** A death summary is required for all deaths regardless of length of stay and must be documented at the time of death but no later than 24 hours thereafter by the responsible practitioner.
- L. **Death Pronouncement Note:** A death pronouncement note is required to be completed at the time the patient is pronounced but no later than 24 hours.
- M. **Transfer Summary:** When patients are transferred to another facility, the transferring physician must dictate a transfer summary regardless of length of stay to include documentation that patient was advised of risks/benefits of transfer at the time of transfer but no later than 24 hours thereafter. To assure the hospital communicates appropriate information to any organization or provider to which the patient is transferred, the transfer summary shall include the following information as appropriate:
1. The reason for the transfer



2. Summary of care, treatment, and services provided and progress toward goals
3. Documentation that the patient was advised of the risks/benefits of transfer
4. The patient’s physical and psychosocial status

N. Amending Medical Record Entries:

1. **Electronic Documents (Structured, Text and Images):** Any individual who discovers his/her own error or omission prior to the authentication of the entry shall immediately, upon discovery, correct the error or omission through the EMR. The EMR will track all changes made to entries. Once an entry has been authenticated and an error is found, the EMR will force the author to record his/her comments in the form of an electronic addendum in which the individual will document the erroneous information, authenticate the entry and the system will date and time stamp the entry. If information is found to be recorded on the wrong patient, regardless of the status of the entry, the EMR will not allow deletion of any entries. The entry recorded in error must be documented as such by the author, and the author must re-enter the information on the correct patient.
2. **Paper-Based Documents:** Any individual who discovers his/her own error or omission prior to the authentication of the entry shall immediately, upon discovery, correct the error by drawing a single line through the erroneous entry, but not obliterating it, and initialing and dating the error. Errors or omissions discovered at a later time shall be corrected by the individual with a new entry. The person making the change shall sign and note the date of the change and reason for the change. Any physician who discovers a possible error made by another individual should immediately upon discovery notify that individual or appropriate unit representative. Upon confirmation of the error, the patient’s attending physician and any other practitioners, nurses or other individuals who may have relied upon the original entry shall be notified as appropriate.

O. Timely Completion of Medical Records:

1. **Complete Medical Record:** The Medical Record is not considered complete until all its essential elements are documented and authenticated, and all final diagnoses and any complications are recorded, consistent with this policy. No medical record shall be considered complete without fulfilling the documentation requirements except on order of the Medical Executive Committee.
2. **Timely Completion of Medical Record Documents:** All medical record documents shall be completed within time frames defined below:

Documentation Requirement	Timeframe	Exclusions
Emergency Department Report	Documented within 24 hours of discharge/disposition from the Emergency Department	
Admitting Progress Note	Documented within 24 hours of admission	
History & Physical	Documented within 24 hours of admission and before invasive procedure	
Consultation Reports	Documented within 24 hours of consultation	
Post Op Progress Note	Documented immediately post op when there is a delay in the	



	availability of the full report.	
Provider Coding Clarification	Documented within 24 hours of notice	
Operative Report	Documented immediately post-op and no later than 24 hours after the procedure	
Special Procedures Report	Documented within 24 hours of notice	
Discharge Summary Report	Documented at the time of discharge but no later than 24 hours after discharge	Not required on all admissions less than 48 hours, or for normal vaginal deliveries and normal newborns
Discharge Progress Note	Documented at the time of discharge but no later than 24 hours after discharge for all admissions less than 48 hours or for normal vaginal deliveries and normal newborns	
Death Summary	Documented at the time of death/disposition but no later than 24 hours after death	
Death Pronouncement Note	Completed at the time the patient is pronounced within 24 hours	
Transfer Summary	Documented at the time of transfer but no later than 24 hours	
Signatures	Authentication of transcribed or scanned reports and progress notes, within 7 days from the date of notice.	
Verbal Orders	Dated, time and authentication within 48 hours from order	

P. **Medical Record Deficiencies:** Physicians are advised of incomplete documentation via the physician inbox. The Health Information Management Services Department shall advise physicians by fax, mail or electronic notice of incomplete medical records. Notice of Incomplete Records will be sent after a qualifying deficiency has met or exceeded the timeframes in Section IV.O.2 above . The notice will include a due date and a list of all incomplete and delinquent medical records.

If a vacation prevents a practitioner from completing his/her medical records, the physician must notify the Health Information Services Department and/or Medical Staff Services Department in advance of the vacation.

If there are extenuating circumstances (defined as illness, extended absences) that prevent the practitioner from completing his/her medical records, the physician or the physician’s office must



notify the Health Information Management Services Department and/or Medical Staff Services Department.

Q. Medical Record Suspension:

1. A member is considered eligible for suspension based on the timeframes in Section IV.O.2 above. If the delinquent records are not completed timely, providers will receive a notice and their admitting and surgical/procedure scheduling privileges will be temporarily suspended until all medical records are completed. A suspension list will be generated and distributed to the Chief of Staff, Facility Medical Director, Administration, Medical Staff Services and applicable hospital departments. A notification will be sent to the above areas once the physician has completed all documentation requirements.
2. Medical Record suspension includes loss of non-emergent Hospital privileges, including elective admissions, scheduling elective procedures, administering anesthesia, consultations and surgery assists.
 - a. Exceptions: Physicians under Medical Records Suspension shall continue to provide the following care:
 - (i) Routine care for his/her own patients already in the Hospital at the time of suspension.
 - (ii) All Emergency Department Responsibilities while on Emergency Department back-up call.
 - (iii) Members shall not be suspended while on vacation or out of town.

R. Continuous Temporary Suspension:

1. If a medical staff member remains on continuous medical record suspension for 30 days, the member will be referred to the Health Information Management Committee for review and possible referral to the Medical Executive Committee.

V. Procedural Documentation:

- A. N/A

VI. Additional Information:

- A. N/A

VII. References:

- A. N/A

VIII. Other Related Policies/Procedures:

- A. N/A

IX. Keywords and Keyword Phrases:

- A. Medical Record
- B. History and Physical
- C. H&P
- D. Progress Notes
- E. Consultations
- F. Operative Reports
- G. Discharge Summary
- H. Transfer Summary



- X. Appendix:**
 - A. N/A